For Washington State Nursing Home staff

From Residential Care Services, Aging and Disability Services
Department of Social & Health Services

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our mascot
Cousin IT

Inside this issue:

"This is I.T." Newsletter

Info and Tips from the MDS-WA Office—***Clinical*** *stuff,* ***Computer*** *stuff,* ***Reports*** *'n stuff, and other STUFF!*

By Marge Ray and Shirley Stirling, State of WA, DSHS

Happy New Year!

Happy New Year!

2010 brings us a brand new decade, one that promises changes, challenges and chances.

We continue to have the opportunity and privilege to provide the best possible care and services to our nursing home residents, beginning with thorough and accurate assessment and care planning. We face challenges in much too much to do and never enough time to get it all done with ever limited resources.

And finally, we begin this new decade with changes. In October the new assessment tool, MDS 3.0, will be implemented bringing new items, processes and payment systems.

For us at Residential Care Services, there is also change. On March 1, Shirley Stirling, our MDS Automation Coordinator and co-author of this newsletter, will retire. **IT** will continue and I will introduce our new automation coordinator in our next issue.

I do want to take this opportunity to thank Shirley for her dedication and tireless efforts to problem solve for all of us and we will all miss her.

Marge Ray

It's a Pain! Assessing and Coding Pain on the MDS

"Every time we try to get Mr. Winters up, he moans a little, swears a little, and tries to hit us." *Wonder what his problem is?*

If the staff asked you, as the MDS nurse, you would no doubt be able to answer that the problem might be pain. Pain can significantly affect a person's well-being as it has both sensory and emotional components. Recognizing and promptly addressing it is very important. It is the most common reason that people seek medical care per data from a 2002 report which found that 45 – 83% of people over 65 have pain.

MDS 2 has two specific items that deal with pain; J2 (frequency and intensity) and J3 (location of pain).

Basic Facts

1. Pain is defined as any type of physical pain or discomfort in any part of the body.

2. Pain is subjective—it is what the person says it is.

3. Pain can be localized to one area or generalized across the body.

4. Pain can be acute or chronic, continuous or intermittent, occur at rest or with movement.

5. If it is difficult to determine the exact frequency or intensity of pain, then code for the more severe level.

Since pain is subjective and all of us experience pain differently, we must depend on the resident to tell us about their pain. Residents do this in many ways, both verbally and non-verbally. So we must use a variety of methods to conduct a thorough assessment.

Interviews

1. **Ask** the resident if pain was present in the last 7 days.

2. **Listen** to what the resident says, use questions like, "Tell me about the pain you had..."

3. **Ask** staff across all shifts and disciplines.

4. **Talk** to the family, find out how the resident usually expresses pain, and if they are aware of times when the resident had pain in the last 7 days.

5. **How** you ask the resident about pain affects the accuracy of the assessment. Saying, "you didn't have any pain last week did you?" will produce a different response than, "Can you tell me about any pain or discomfort you had in the last 7 days?"

Marge ***Shirley***

Our goal... Our goal is to help you accurately assess, code, and transmit the MDS. Accurate assessment forms a solid foundation for individualized care to help residents achieve their highest level of well-being.

Observations

Look for indicators of pain or possible pain:

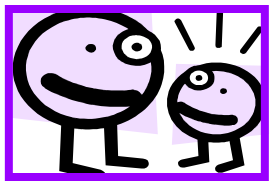
1. **Facial expressions** such as frowns, grimacing, pinched eye brows.
2. **Verbalizations** such as moaning, crying, pleas for help.
3. **Body posturing** as if to protect body parts.
4. **Restlessness**, fidgeting, rocking, rubbing.
5. **Changes in normal patterns** such as eating, attending activities, sleep.
6. **Resisting care,** verbal or physical abusiveness, pacing.

Record Reviews

Review the Medication Administration Records (MAR) to see if any PRN medications for pain were given (even one dose during the 7 day look-back period counts for coding J2a).

Look at progress notes including but not limited to those from nursing, therapy, social services, activities, and physicians.

Connecting the MDS Dots



Item J2 - Pain Symptoms
Item J3 - Pain Site

For Quality Monitoring as well as Care Planning

Not only is the data from J2 andJ3 used for care planning purposes, it is also used for **quality monitoring**. Entries in J2a reflect Frequency of Pain in the last 7 days and J2b reflects Intensity of Pain in the last 7 days.

QI/QM Reports
Quality Indicator/Quality Measure (QI/AM) 8.1 *Residents who have moderate to severe pain*, uses data from J2a (pain frequency) and J2b (pain intensity). If J2a =2 (pain daily) and J2b=2 (moderate intensity) or J2b=3 (intensity horrible or excruciating) and J2a=1 (pain less than daily) or 2 (pain daily) the assessment will flag as having met the criteria for this measure.

Survey Inspections
When the total number of assessments that meet this criteria are at or above the 75th percentile, surveyors must investigate this during the annual inspection as an area of concern.

5-Star Reporting
Pain is one of the 10 Quality Measures used in the 5-Star Reports that are posted for public review on the Nursing Home Compare Internet site.

Federal Survey Tag F309
Pain is a frequently cited item under F309. To comply with F309, NHs need to examine how they assess and manage pain in all residents, including the cognitively impaired.

What to expect in Pain Assessment with MDS 3.0

Coding for pain under Section J Health Conditions of the MDS 3.0 has increased in length, compared to MDS 2.0 but should actually be easier to complete and more accurate. There will be a screening process under the MDS 3.0 to determine if a resident is able to complete the interview

The pain assessment will include the following:

1. The effect of pain on functionality,
2. More frequency choices, and
3. The inclusion of either a numeric rating scale using a 0-10 range or a verbal descriptor assessment.

The Pain Assessments Interview (MDS RAI Manual, Chapter 3, items J3 to J6) MDS 3.0 has a 5-day look back period rather the 7-day look back that we have with MDS 2.0. Why change it to 5 days? The MDS 3.0 pilot test show a better ability for people to recall when the look back is not over 5 days.* (Please note: most other MDS items have a 7-day look back.)

Definitions and examples pertaining to pain are framed in text boxes and interspersed throughout the RAI Manual section. Also, there will be items to identify pain management techniques including the use of PRN or scheduled medication regimens as well as non-medication interventions.

For residents who are unable or unwilling to participate in the pain interview, they revised items for staff evaluation to include non verbal sounds, vocal complaints, facial expressions and protective body posturing.

In MDS 3.0, there will also be a new Care Area Assessment for pain. Care Area Assessments will replace the current RAP process.

Do we expect improved outcomes with pain assessment in MDS 3.0?

In a word, yes! It is interesting that in Phase 2 of the MDS 3.0 item development the Veteran's Administration (VA) conducted a pilot in partnership with Harvard Medical School and Centers for Medicare and Medicaid Services (CMS).

The VA Pilot developed and tested MDS Items in 8 areas: mood, behavior disorders, mental status, delirium, **pain,** falls, quality of life, and diagnostic coding.

In the area of pain, the VA research findings were:

1) That self-report is feasible and efficient;
2) That it yields more valid estimates than observation;
3) That ascertaining impact on function is feasible and provides useful information.

During testing:*

- 91-97% of nurses rated the pain management item definitions as clear.
- 88% rated MDS 3.0 pain items as improved over MDS 2.0.
- 94% reported that new pain items could inform care plans.
- 90% felt that all residents who responded understood. (3% disagreed)
- 85% felt the observable behaviors would improve reporting of possible pain.
- Even during testing, pain interview provided new insights into resident's pain (85%)

Source: slides from: MDS 3.0 Special Open Door Forum January 24, 2008

Personal Pain Quiz

Our own experiences and beliefs about pain can impact our assessment. Ask yourself the following questions:

- Do I have pre conceived ideas or biases when I assess for pain?
- Do the staff know when and to whom to report resident's pain symptoms
- Are all staff trained to recognize pain?
- Do the residents know how to report pain?
- Do we use validated assessment tools?
- Do I routinely ask my residents about their pain status?

Pain - The 5th Vital Sign

When you get a check-up, they usually take your vital signs:

Temperature
Blood pressure
Pulse
Respiratory Rate

Pain is now being reported as the 5th vital sign. It is different for each person and just may be the hardest to measure.

How <u>much</u> does it hurt? Increasingly the 0-10 measurement scale is being used and the use of this scale in the upcoming MDS 3.0 will allow more reliable comparison across care settings.

Quick Review:
Coding J2 and J3 in MDS 2.0
Both are 7-day look back periods

J2 Pain Symptoms, records two items: the frequency or **how often** the resident complains or shows evidence of pain (J2a) and the **intensity** or severity of the pain as described or manifested by the resident (J2b).

The MDS 2.0 coding choices for **J2a** are:

- **0 - No pain (if this is the answer, do not complete J2b or J3, skip to J4)**
- **1 - Pain present but not daily**
- **2 - Pain daily**

Ask the resident if they have had any pain in the last 7 days; also observe for any indicators of pain. If the resident says they had pain, accept it and code it. For residents who cannot tell you, rely on observations of others for pain indicators including behaviors.

If a resident is on a routine pain management program but has no complaints of pain or does not show any evidence of pain during the look-back period, code "0" No pain.

The MDS 2.0 coding choices for **J2b** are:

- **1 - Mild Pain**
- **2 - Moderate Pain**
- **3 - Horrible or Excruciating Pain**

Since most facilities use additional pain assessment scales to more accurately determine the intensity of a resident's pain, be sure that a conversion process/crosswalk has been devised to translate the pain scale you use to the MDS, this will help ensure consistency in the reporting of pain intensity. For example, a 10 point pain scale where 0 is no pain and 10 is the worst possible pain could be converted for staff so that a rating of 1-3 is equal to Mild Pain for the MDS, 4-7 is Moderate Pain and 8-10 is considered Horrible or Excruciating Pain.

Use your best clinical judgment. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level.

J3 Pain Site asks you to check all sites where the resident had pain during the past 7 days. Obtain this information from interviews and observations. If the resident has mouth pain, evaluate it for frequency and intensity and record that information in J2, but record the site of the pain in item K1c.

Q2IT Treasure Trove Tips

- The use of pain medications should not cause a resident to trigger for pain. The RAI Manual states that the pain item should be coded according to the level of pain present during the look back period, not according to interventions .

- <u>Common shortcomings in pain management</u>:
- Using **PRN medications** to treat pain at a time **when an around-the-clock regimen** would be more appropriate.

- Prescribing **PRN medications** for cognitively impaired residents who may be **unable to ask** for help or to **communicate their pain.**

- **Failing to anticipate pain** before pain-inducing activities, such as therapy or wound-dressing.

About Pain… What Now?

The identification of pain is only the beginning. <u>Care planning</u> for pain comes next. There are questions that naturally follow the initial assessment:

- If pain is present, what is being done about it?

- Are the interventions we have effective?

- Are we proactive?

1 - Does the resident's disease or condition typically cause pain as a symptom?

2 - Do we anticipate pain before certain procedures are done such as dressing changes or before therapy and provide pain interventions?

What type of documentation do we have? Is it easy to find? Is it understandable? Is it accurate?

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MDS 3.0 - One Year & Counting

CMS continues to post chapters to the MDS 3.0 manual on their website. So far, Chapters 1, 3, 5, 6 and all appendices except "C" are available. Chapter 2, Chapter 4 and Appendix C are expected by the end of January.

CMS training efforts are underway as follows:

- The first of three planned satellite broadcasts was held Dec 17, 2009 and can be viewed at http://surveyortraining.cms.hhs.gov/ No specific dates are set yet, for the other two, but the next programs are planned for **May/June 2010 – *How to code the MDS 3.0*.** and **June/July 2010 - *Impact on LTC survey processes and payment system.*** You can either join the live broadcasts on 'the day' or listen to the recorded program at your leisure. Each will be posted for 1year.

- Two **train-the-trainer conferences** will take place in Baltimore this spring. One for state agency RAI coordinators, long-term care surveyors, and state Medicaid agency representatives. The other is for nursing home providers, stakeholders and professional groups and associations.

- A series of training **teleconferences for software vendors** is also occurring and will soon be available online.

- A **web-based interactive training** program will be developed and made available in the summer of 2010.

- A nursing home distance-based training opportunity, possibly in the form of a **Webinar or Open Door Forum** , to allow providers to hear about the MDS 3.0 directly from CMS may also occur in the spring or summer of 2010.

Washington State MDS 3.0 Training

Washington State MDS 3.0 training will be held mid June through the first week of August at 11 sites around the state. The training is being conducted by Residential Care Services (RCS) in collaboration with the two nursing home provider associations, Washington Health Care Association (WHCA) and Aging Services of Washington (ASWA). ***For our out of state readers:*** contact the state MDS office in your state for local training plans.

For Washington State nursing home, please register with:

Pat Sylvia ASWA Phone: 253-964-8870 Email psylvia@agingwa.org

OR

Brenda Orffer WHCA Phone: 360-352-3304 Email brendaorffer@whca.org

Fee $149 per person or $129 each with 3 or more registered.

MDS 3.0 Training Schedule

June 17-18, 2010 Wenatchee
June 21-22, 2010 Vancouver
June 24-25, 2010 Olympia
June 29-30, 2010 Yakima
July 8-9, 2010 Bellevue
July 12-13, 2010 Tacoma
July 15-16, 2010 SeaTac
July 19-20, 2010 Silverdale
July 22-23, 2010 Mt. Vernon
July 27-28, 2010 Spokane
Aug 2-3, 2010 Kennewick

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Info for NH Professionals
http://www.aasa.dshs.wa.gov/professional/nh.htm

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NH Rates and Reports
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ProviderOne Phase One
http://www.adsa.dshs.wa.gov/professional/providerone/

ADSA on the Web!

http://www.adsa.dshs.wa.gov/Professional/

Computer Corner

I will use Computer Corner this time to send out an early **good-bye and thanks** to all our readers and nursing home staff for making this job fun and satisfying. It is a delight to know you and I will really miss you all!

Marge and I have had lots of fun with this newsletter, our Listserv, websites and help desk. I hope we have made your jobs a bit easier, made the MDS more understandable, and brightened your day in our contacts with you.

I started this position in 2003 and have never regretted it. I have had a great group of people internally to work with both at RCS and Rates. I have been able to have people contact (help calls) an artistic outlet (newsletter), a chance to write regularly (listserv, website, and newsletter), and the mental challenge of designing and using databases, queries, formulas, spreadsheets, and - best of all - helping figure out conundrums! Thank you - this has been a great experience and I will miss you all a lot.

I am not just leaving this job but retiring from 30 years in state government. I am going now so that I can assist with family care giving responsibilities. I hope that all goes well with MDS 3.0 and if I can help out in some way in the future, I will be glad to do so. I know DSHS is doing a great job in hiring in my position and I will, or course, cross train the new person before I leave.

My parting advice: Above all, never forget that the care, safety and quality of life for nursing home residents is what our work is really all about.

Shirley Stirling